This form can be filled out while viewing in Adobe Acrobat Reader. Print it, then fax or mail to the address below.

Alabama Medicaid Agency
P.O. Box 5624
Montgomery, AL 36103-5624

HEALTH INSURANCE
PREMIUM PAYMENT REFERRAL/APPLICATION

Insurance Premium Payment
Telephone (334) 242-3722
FAX (334) 353-4740

Name of Applicant	Medicaid number
Social Security number	Telephone number
Applicant address	

Policy Status (Check appropriate box) ☐ Policy wil l lapse on _____ ☐ Policy lapsed on _____
☐ Medical coverage available, but not applied for. ☐ COBRA extension -- extension end date _____

Type of coverage your insurance provides or pays for (check all that apply)

☐ Hospital stays ☐ Hospital outpatient (i.e., lab work or physical therapy) ☐ Vision care
☐ Medicare supplement ☐ Dental care ☐ Prescription drugs
☐ Doctor visits ☐ Cancer policy ☐ Other - specify

Policy number	8. Premium amount $ _____ ☐ Per month ☐ Per Quarter ☐ Per year

How are premiums paid? (check appropriate box) ☐ Paid by insured to insurance carrier ☐ Employer paid ☐ Payroll deducted

Name of insured policyholder	Social security number	Telephone number
Address of insured policyholder		

Name(s) of other Medicaid eligible family member(s) covered under the health insurance policy

_____ _____

_____ _____

Do you or any other covered beneficiary have an acute, chronic, pre- existing illness that requires him/her to see a physician?

☐ Yes If yes, please specify the person's name and the illness _____
☐ No _____

Name of insurance company, employer or union where premiums are mailed and processed

Address of insurance company, employer or union

Employer name	Employer telephone number
Employer Address	

15. List additional health insurance coverage, if any (complete a separate health insurance payment referral)

IMPORTANT: As a condition of eligibility, all Medicaid beneficiaries shall assign rights to insurance, support, or other third-party payments to the Medicaid program and shall cooperate with the Alabama Medicaid Agency in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medicaid program. Assignment of medical rights allows Medicaid to recover funds from health insurance companies of funds when the Medicaid program pays for medical services which should have been billed to other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42USC, Section 552a) your Social Security number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Submitted information is considered confidential and disclosed only as necessary for Medicaid Program administrative purposes.

AUTHORIZATION: I hereby authorize the Alabama Medicaid Agency to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care on my behalf, which may be used in determining if the Agency will pay health insurance premiums for continued coverage. If the Agency approves payment of my premiums, I agree, as a condition of Medicaid paying this premium, to use insurance plan providers if so restricted. I also agree to furnish to Medicaid copies of benefits (EOBs) and medical bills as needed for Medicaid to evaluate the cost effectiveness of Medicaid paying my premiums.

Signature of Medicaid recipient (or parent or guardian if a minor) **Date**